TRICARE Central

TRICARE Prime Remote Enrollment Application

TriWest Healthcare Alliance

Please return this Enrollment Form to: TriWest Healthcare Alliance, P.O. Box 42178, Phoenix, AZ 85080

PERSONAL INFORMATION:

Social Security #	Last Name	First Name	Middle Initial	Rank	Branch of Service	Date of Birth (mm/dd/yy)

Residential Address	City	State	ZIP	Residential Telephone #
				( )

UNIT INFORMATION:

Unit Name (With Duty Assignment Location)

Address (Duty Assignment Location)	City	State	ZIP	Unit Telephone #
				( )

Transferring enrollment from another TRICARE region? ☐ Yes ☐ No If yes, which region/state or country _____

Have you completed a Health Enrollment Assessment Review (HEAR) survey in the past 18 months? ☐ Yes ☐ No

PRIMARY PHYSICIAN INFORMATION (Family Practitioner, Internal Medicine):

Physician's Name	Address	City	State	ZIP

Telephone #	Is this your current physician? ☐ Yes ☐ No	Specialty
( )		

PHYSICIAN INFORMATION: (List other physicians seen regularly, not including dentist.)

Physician's Name	Specialty	Telephone #	City	State
		( )		
		( )		
		( )		
		( )		

AUTHORIZATION:

Signature	Title (if signing as Unit Commander)	Date of Signature

AGENCY DISCLOSURE STATEMENT: Public reporting burden for this collection of information is estimated to average 15 minutes per Enrollment Form, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Department of Defense, Washington Headquarters Services, Directorate of Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4302, and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington, DC 20508. PLEASE DO NOT RETURN YOUR ENROLLMENT FORM TO EITHER OF THESE ADDRESSES.

PRIVACY ACT STATEMENT: (1) Authority: 5 USC 522a, 10 USC 1079 and 1086, 58 FR 45318. (2) Purpose: To evaluate eligibility for medical care provided by civilian sources to Military Health System beneficiaries applying for the coverage under the TRICARE program (32 CFR, Part 199.17). (3) Uses: Information from Enrollment Forms and related documents may be given to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

FOR INTERNAL USE ONLY:	Date Received	Completed by RACF ID# _____ Date Completed _____

TRICARE Central

TRIWEST HEALTHCARE ALLIANCE®

TRICARE Prime Remote
Enrollment Application Instruction Sheet

Welcome to TRICARE Prime Remote. To participate in the program, complete the TRICARE Prime Remote Enrollment Application and return it to the address printed on the top of the application. The completed application provides TRICARE with the information necessary to enroll you in the program.

There are five sections to the application:

1. *Personal Information*: Provide information about yourself only, not family members. At this time, family members are not eligible for the TRICARE Prime Remote program in the TRICARE Central Region. Your residential address should reflect where you are living during your current assignment.
2. *Unit Information*: This section will help us to identify where you are located for active duty service. IMPORTANT: Please indicate the address where you actually report for work rather than a central unit location.
3. *Primary Physician Information*: If you are in an area where a TRICARE Prime primary care manager (PCM) is available to you, choose a TRICARE Prime PCM, and enter his or her information in this section. If a TRICARE Prime PCM is not available, or if you are unsure, please enter the name of any physician from whom you seek primary health care in this section.
4. *Physician Information*: In this section, list all other physicians you see regularly (excluding dentists).
5. *Authorization*: Your signature authorizes that you wish to be enrolled in the TRICARE Prime Remote program. A Unit Commander may also sign this application. If you are a Unit Commander, also include your title to verify that you are signing as a Unit Commander on behalf of the applicant.

As you complete the application, please:

- print clearly in ink.
- provide accurate, detailed information.
- keep the yellow copy for your records.

A sample of a completed application is included for you to use as a guide when completing the form. If you have any questions, please call toll-free at 1-877-554-2224.

Again, welcome to TRICARE Prime Remote. We look forward to serving you.